PRINTED: 02/15/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		165533	B. WING			02/01/2022	
	ROVIDER OR SUPPLIER	C		STREET ADDRESS, CITY, STATE, 2 1111 11TH AVE NORTH HUMBOLDT, IA 50548	ZIP CODE	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD THE APPROPI	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMEN	ΓS	FC	000			
	Correction Date Investigation of faci	lity complaints #100218-C,					
	#100329-C, #10142	26-C, #101430-C, #101451-C, 01431-M completed					
	Complaint #100329 Complaint #101426 Complaint #101430 Complaint #101451 Complaint #101560 Investigation of faci	was not substantiated. was substantiated. lity mandatory reports d in the following deficiency.					
	was conducted 1/5/ found to be in comp	ed Infection Control survey /22-2/1/22. The facility was bliance with CMS and Centers and Prevention (CDC) ctices to prepare for					
F 550 SS=D	See Code of Feder 483, Subpart B-C. Resident Rights/Ex CFR(s): 483.10(a)(	· ·	F 5	550			
	self-determination, access to persons	nt Rights. right to a dignified existence, and communication with and and services inside and including those specified in					
LARODATOR		ility must treat each resident	NATUDE	TITLE			(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 550	resident in a manner promotes maintenather quality of life, reindividuality. The far promote the rights  §483.10(a)(2) The access to quality caseverity of condition must establish and practices regarding provision of services residents regardles  §483.10(b) Exercise The resident has the rights as a resident or resident of the US  §483.10(b)(1) The resident can exercise interference, coerce from the facility.  §483.10(b)(2) The free of interference reprisal from the far rights and to be supexercise of his or his subpart.  This REQUIREMED by:  Based on clinical reinterviews, the facility and residents and in a manner cares and in a manner cares.	gnity and care for each er and in an environment that ance or enhancement of his or ecognizing each resident's acility must protect and of the resident.  facility must provide equal are regardless of diagnosis, and, or payment source. A facility maintain identical policies and a transfer, discharge, and the es under the State plan for all as of payment source.  e of Rights.  the right to exercise his or her are of the facility and as a citizen	F 5	50		

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F 550	(Resident #1) The residents.  Findings include:  A Minimum Data S dated 9/29/21 docuding an one of the disorder, bipolar disorder, bipolar disorder. The asseresident with a Brief (BIMS) score of 5 cand as dependent daily living.  A Care Plan (not dangle Resident with Foculative disorder) a history of a head and a self care defined to the care d	age 2 facility reported a census of 39  et (MDS) assessment form amented Resident #1 with uded a personal history of a ary, psychosis, personality sorder, aphasia and a seizure assment documented the of Interview for Mental Status out of 15 (severely impaired) on staff with his activities of ated) documented the as areas that included an cess/communication related to injury/traumatic brain injury ficit related to impaired mobility s with a diagnosis of traumatic	F 5	50			
	B, Certified Nursing herself and Staff A, from his bed to his placed the w/c over Staff B stated she to good about the situ transfer. At that poshe said give me the which time Staff B proceeded to lower had been lowered to the right staff beforehead and the	on 1/5/22 at 2:27 p.m. Staff g Assistant (CNA) stated when CNA transferred the resident wheel chair (w/c) Staff A rethe left leg of a lift device. Told Staff A she had not felt lation and the lift device bint Staff A cussed at her and the f-ing (explicit) remote at just backed up. Staff A rethe resident down. Once he down into the w/c the lift device side and hit him in the eye and the resident screamed really bleeding really bad. Staff B					

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F 550	somebody. Staff A we just need to cleopened the resider the f*&= (explicit) h	A they needed to get said the f*&= (explicit) we do, an him up. Then Staff A nt's room door and said where ad been Staff C, LPN. Staff C and measured and cleansed the	F 5	50		
F 584 SS=E	when Staff B stood Safe/Clean/Comfort CFR(s): 483.10(i)(2 §483.10(i) Safe En The resident has a comfortable and ho	vironment. right to a safe, clean, omelike environment, including eceiving treatment and	F 5	84		
	homelike environmuse his or her perspossible. (i) This includes enreceive care and sophysical layout of thindependence and (ii) The facility shall the protection of the or theft.  §483.10(i)(2) Hous services necessary and comfortable in	e, clean, comfortable, and lent, allowing the resident to onal belongings to the extent suring that the resident can ervices safely and that the ne facility maximizes resident does not pose a safety risk. I exercise reasonable care for e resident's property from loss ekeeping and maintenance to maintain a sanitary, orderly,				

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F 584	Continued From pa	age 4	F 5	84			
		te closet space in each specified in §483.90 (e)(2)(iv);					
	§483.10(i)(5) Adequevels in all areas;	uate and comfortable lighting					
	levels. Facilities init	fortable and safe temperature tially certified after October 1, n a temperature range of 71 to					
	sound levels. This REQUIREMED by: Based on observation facility failed to assisted clean, sanitary and	ne maintenance of comfortable  NT is not met as evidenced  tion and staff interview, the ure residents resided in a homelike atmosphere. The census of 39 residents.					
	Findings include:						
	a. A build up of the flooring as a pe along the wall and b. A toilet with ca large amount of tup of a brown subsarm rest of the toiled.	on 1/5/22 at 12:29 p.m. ing in the shower room of the fusion or a dementing illness):  a thick brown substance along erson entered the shower and baseboards. discolored brown/tan water with oilet paper not flushed. A build tance on the right and only et and a build up of a brown e base of the toilet and the 2					
	floor tiles in front of c. A 2 layer met along the wall with						

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F 584	white substance.  2. An observation or revealed the following down the 200 hallwards a. A build up of back of the toilet seathered to the toilet.  3. An observation or revealed the following a. A build up of	n 1/5/22 at 12:36 p.m. ng in the shower room located ay: a brown substance along the at where arm rests are t itself. on 1/7/22 at 10:51 a.m.	F5	584		
	behind and around 405.  During an interview Certified Nursing As felt the facility as ur  During an interview B, CNA confirmed to She described rust toilets always smell Services Provided I CFR(s): 483.21(b)(3) Com The services provides outlined by the comust- (i) Meet professional This REQUIREMEN by: Based on observations	on 1/5/22 at 1:45 p.m. Staff F, ssistant (CNA) indicated she nclean.  on 1/4/22 at 2:27 p.m. Staff he facility as not clean at all. in the sinks and the residents ed.  Meet Professional Standards	F 6	558		

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F 658	residents reviewed The facility identification of the facility	llow physician's orders for 3 of 4 dd, (Resident #3, #4 and #6) fied a census of 39 residents.  Cation Administration Policy form ed the following: In the policy of the facility to have dications in a safe, consistent administration times placed to the therapeutic effects and effects.  Procedure form (not dated) and e contained the following rames of 6 a.m. to 10 a.m., 2 to 10 p.m The 1 hour before also pertained to the medication dation turns yellow in Point Click effects and the staff could have medications within the allotted fic times, example 7 a.m. the a.m. until 8 a.m. to have	F	558			

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F 658	Resident #4 receive as timed:  a. Norco (Hydrotablet 7.5-325 millig (po) 4 times a day rhabdomyolysis, aga current pathologicand administered 2 3 p.m. and administered 2 3 p.m. and administered 2 3 p.m. and administered at 6.4 c. Triple antibio her left ear topically her left ear (cancer administered at 6.4 d. Senna-S (lax tablets po in the aft administered at 5.3 During an interview Resident #4 stated medications about 11 a.m. The reside Practical Nurse (LF Medication Aide fol administration of the D confirmed this st surveyor approach immediately after the Staff D had be documented she amedications on the Record (MAR). Sta	ed the following medications occodone) (pain medication) gram (mg) 1 tablet by mouth (QID) related to ge related osteoporosis without cal fracture ordered at 11 a.m. 2:33 p.m. and also ordered at stered at 5:37 p.m.  (diabetes mellitus) tablet 100 a day (TID) ordered at 11 a.m. at 2:33 p.m.  tic ointment with application to y TID related to disorders of condered at 12 p.m. and 18 p.m.  (ative) tablet 8.6-50 mg 2 ternoon ordered at 2 p.m. and	F 6	58			

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F 658	on the staffing and occurred on a give on to say she could had been supposed surveyor what really. During an interview E confirmed she parmedications upon related the following and tablet po QID age related osteopopathological fracturadministered at 12:50 p.m.  c. Triple antibiosher left ear topicallyher left ear (cancer administered at 6:5 d. Senna-S (lax tablets po in the aft administered at 4:0 4. During an intervent Resident #3 (identific confirmed there had supposed to the say of the s	resident circumstances that in day. The staff member went it tell the surveyor what she it to say or she can tell the y happened.  I on 1/18/22 at 1:55 p.m., Staff it issed the resident her equest of Staff D.  Interest in Administration Audit 1/18/22 documented Resident owing medications as timed:  I ocodone) (pain) tablet 7.5-325 related to rhabdomyolysis, prosis without a current e ordered at 11 a.m. and 50 p.m.  Interest in the provided in	F 6	58		

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F 658	Review of a Medica Report form dated resident received the timed:  a. Tylenol extra morning scheduled 11:50 a.m. and in the p.m. and administed to a c. Zyprexia (de tablet po in the morning scheduled at 8 p.m. and in the p.m. and administered at 11: scheduled at 8 p.m. and in the morning scheduled at 8 p.m. d. Furosemide po in the morning sadministered at 11: scheduled at 11:50 a.m.  f. Metoprolol (morning scheduled 11:50 a.m.  f. Metoprolol (hand administered at 11: scheduled at 11: scheduled at 11: scheduled 11:	ation Administration Audit 1/13/22 documented the the following medications as a strength 2 tablets po in the d at 6 a.m. and administered at the evening scheduled at 8 ared at 10:15 p.m.  100 mg 1 capsule po in the d at 6 a.m. and administered at the evening scheduled at 8 ared at 10:15 p.m.  Ilusional disorder) 2.5 mg 1 rning scheduled at 6 a.m. and at 50 a.m. and in the evening and administered at 10:15  ( hypertension) 40 mg 1 tablet accheduled at 6 a.m. and account 300 mg 1 tablet po in the d at 6 a.m. and administered at a ypertension) extended release a morning scheduled at 6 a.m. at 11:50 a.m.  nutritional anemia) 20 mg 1 rning scheduled at 6 a.m. and	F 65				

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 658	i. Metamucil Poin the morning schadministered at 11 j. Amlodipine bhyperlipidemia) 5 r 6 a.m. and administered at 11:50 a.m. l. Simvastatin (poin the evening sadministered at 10:50 a.m. l. Simvastatin (poin the evening sadministered at 10:50 a.m.  Simvastatin (poin the evening sadministered at 10:50 a.m. Amodication Secriteria form signe 6/1/21 documented administer her medical decording to an endirector of Nursing as set up by qualifiting set up by qualifiting set up by qualifiting as set u	owder 28.3% 1 tablespoon poreduled at 6 a.m. and 250 a.m.  esylate (hypertension and 150 a.m. esylate 1 poin the morning at 150 a.m. estered at 11:50 a.m.  expression) 100 mg 1 tablet poin a.m. and administered at 150 a.m. espression) 40 mg tablet 1 a.m. and administered at 150 a.m. espression) 40 mg tablet 1 acheduled at 8 p.m. and 215 p.m.  elf-Administration Assessment d by a Nurse Practitioner d Resident #6 as able to self dications.  enail 1/28/22 at 12:39 p.m. the 1 (DON) confirmed medications ed staff and delivered to the ministration. Staff had not	F 65	8		

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F 658	stand full of round of shelf of the table. The shelf of the table of the staff she felt no pain at the she stored the pills. The she stored the pills of the burgur of the pills of the	of the resident's bedside white pills that spilled onto the The resident identified the pills had given her routinely but if the time of the administration in that paper medication cup.  on 1/8/22 at 2 p.m. the DON andy oval capsule as the counter eye vitamin and the counter eye vitamin eye vi	F 65	8		
F 677 SS=D	made sure the med resident.  ADL Care Provided CFR(s): 483.24(a)(  §483.24(a)(2) A resout activities of dail services to maintain personal and oral h	ident who is unable to carry y living receives the necessary n good nutrition, grooming, and	F 67	7		

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F 677	staff interview, the provided baths/sho schedules for 1 of Resident #3). The 39 residents.  Findings include:  1. During an interview (alied to have showed failed to have showed and and and and and and and and and an	record review, resident and facility failed to ensure staff twers according to resident 4 residents reviewed, ( facility identified a census of riew on 1/7/22 at 1:24 p.m., fied as interviewable by the there had been occasions staff wered her on her scheduled and Thursdays due to staffing ant confirmed she wanted her d.  Deathing form and neets revealed staff failed to the the resident as	F 6	77		
F 689 SS=G	baths as all messe		F 6	89		

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F 689	CFR(s): 483.25(d)( §483.25(d) Accider The facility must er §483.25(d)(1) The as free of accident §483.25(d)(2)Each supervision and as accidents. This REQUIREME by: Based on observa staff and resident in ensure staff mainta environment for 2 (Resident #1 and # census of 39 reside Findings include:  A Minimum Data S dated 9/29/21 docu Brief Interview for M 5 out of 15 (severe dependent on 2 sta and non-ambulator mobilization.  The Care Plan doc potential for injury, history of a head in convulsions, (not d	1)(2)  nts. nsure that - resident environment remains hazards as is possible; and resident receives adequate sistance devices to prevent  NT is not met as evidenced tion, clinical record review, nterviews, the facility failed to ained a safe and secure of 4 residents reviewed.  5) The facility identified a	F 68	,			
	An Incident Report p.m. documented S	ff members. (not dated)  form dated 12/22/21 at 4:10  Staff A, Certified Nursing ported to Staff C, Licensed					

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F 689	Practical Nurse (LF new skin tear after face during a trans resident and found on the left cheekber centimeters (cm) leforehead that meas witness statement entry: "when we wfrom the bed to his wheelchair on one (hoyer legs were si was lowered becaut of the hoyer legs thron the top of the hohead.  During an interview B, Certified Nursing herself and Staff A from his bed to his placed the w/c ove Staff B stated she if good about the situ transfer. At that posaid give me the fitime Staff B just be lowered down into tipped to the right staff bud and he began said she told Staff A we just need to cle opened the resident the f*&= (explicit) is	PN) the resident received a the lift device hit him in the fer. The LPN assessed the he sustained 2 skin tears, 1 one that measured 1.5 ong and 1 on the upper sured 0.5 cm in diameter. The section contained the following ere transfering the resident wheelchair, Staff A put the of the lower legs of the hoyer deways). When the resident use the wheelchair was on one he hoyer tipped, and the bars over landed on the residents of on 1/5/22 at 2:27 p.m. Staff and A sasistant (CNA) stated when and CNA transferred the resident wheel chair (w/c) Staff A rethe left leg of a lift device bint Staff A cussed at her and sing (explicit) remote at which acked up. Staff A proceeded to down. Once he had been the wheel chair the lift device side and hit him in the eye and the resident screamed really bleeding really bad. Staff B A they needed to get as aid the f*&= (explicit) we do, an him up. Then Staff A it's room door and said where a staff C, LPN. Staff C then easured and cleansed the	F 68	9			

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		165533	B. WING _		02	/01/2022	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1111 11TH AVE NORTH HUMBOLDT, IA 50548		02/01/2022		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 689	During an interview B confirmed again not feel good about times because all to the wheel chair in forotocol. Staff B at the remote for the because Staff A haused her right knew wheel chair which held the resident which and then from a lift device. Staff A indicated the lift device, the lopen appropriately left leg of the lift debeen correct. Staff positioned on the water of the ground as Staff A sher right leg of the ground as Staff A sher right hand and back into the w/c at the lift device came device hit his face. catch it but was nothere had been no would have protect.	o on 1/7/22 at 10:36 a.m. Staff that she told Staff A she did t the transfer approximately 6 they would of had to do is move front of the lift device per lso confirmed Staff A grabbed lift device out of her hand d a free hand because she to maintain the position of the had been tilted back as she		39			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L. TIDENTIFICATION NUMBER.		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		165533	B. WING		02	/01/2022	
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP 1111 11TH AVE NORTH HUMBOLDT, IA 50548			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 689	eye but it all happe confirmed the resindicated Staff B faster to get the sidevice had not we pulled the resider device some roor like that and remostraps Staff A posithe w/c as she that After the lift device moved him back, onto the ground a of the way and w Staff A denied evitell the nurse. Staword f*&^ (explicited did nothing. Whe Staff C he came that and cleaned up the area above the right he area below the Staff A confirmed properly position million years ago done wrong.  During an interview confirmed that on him at the nurse's injury. When he contains a staff of the staff of th	be hooking devices hit below his bened so fast. Staff A then sident yelled out in pain. Staff A tried to get the lift device down straps off the lift device but the orked properly. Staff A then not back a little bit to give the lift m and get the straps and stuff oved. After they removed the sitioned the resident further in hought Staff B just stood there, see had been tipped and she she moved the lift device back and repositioned the resident out went to retrieve the nurse.  Wer having directed Staff B not to aff A confirmed she said the the when Staff B stood there and en she reported the incident to to the resident's room assessed the blood. Staff A indicated the ght eye was bleeding more than	F	689			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		165533	B. WING_		02	/01/2022
NAME OF PROVIDER OR SUPPLIER  QHC HUMBOLDT NORTH, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1111 11TH AVE NORTH HUMBOLDT, IA 50548		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 689	- ·	staff never told him he was	F 68	39		
	Director of Nursing expected the staff to	on 1/11/22 at 2:17 p.m. the (DON) confirmed she o properly position the een the legs of the lift device				
	Resident #5 (identif facility) confirmed the members transferred	iew on 1/7/22 at 10:04 a.m., fied as interviewable by the here had been times staff ed him in a standing lift device mber present however he felt				
	Certified Nursing As	on 1/5/22 at 1:45 p.m. Staff F, ssistant (CNA) confirmed she ts who required 2 staff elf.				
F 725 SS=F	the DON confirmed assistance with all r	Staff	F 72	25		
	the appropriate con provide nursing and resident safety and practicable physica well-being of each r resident assessmen	nt Staff.  Ive sufficient nursing staff with inpetencies and skills sets to id related services to assure attain or maintain the highest I, mental, and psychosocial resident, as determined by ints and individual plans of care is number, acuity and				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED	
		165533	B. WING		02	/01/2022
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z 1111 11TH AVE NORTH HUMBOLDT, IA 50548	· · · · · · · · · · · · · · · · · · ·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES :Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 725	accordance with that §483.70(e). §483.35(a)(1) The by sufficient numb types of personnel nursing care to all resident care plans (i) Except when was this section, licens (ii) Other nursing plimited to nurse aid §483.35(a)(2) Exceparagraph (e) of the designate a licens nurse on each tou This REQUIREME by: Based on resider facility failed to ensineeds were met in than 15 minutes) f (Resident #3, #4 a census of 39 resident #3 (ident facility) confirmed an hour as she useroom which cause  2. During an internal Resident #4 (ident facility) stated the	facility's resident population in the facility assessment required a facility assessment required a facility must provide services are of each of the following on a 24-hour basis to provide residents in accordance with state and a cordance with state and bersonnel, including but not des.  The facility must are defined and staff interviews, the state resident call lights and a timely manner (no longer or 3 of 4 residents reviewed, and #5) The facility reported a tents.  The facility reported a tents.	F 7	725		

` ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		165533	B. WING			02/	01/2022
	PROVIDER OR SUPPLIER	С		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1111 11TH AVE NORTH HUMBOLDT, IA 50548		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPORTION OF T	BE	(X5) COMPLETION DATE
F 725	handed. The resider routine Hydrocodor arthritis When ask stated she had beer rose to a 7 (with 10 when she had to w call light 5 times ar staff answered they short-staffed. By the she was shaking be mostly because of 3. During an interval Resident #5 (identificatility) confirmed i light on for up to 25 positioned on the cresident felt the state enough staff to me the residents.  4. During an interval Staff F, Certified N confirmed staff as lights within the allowhich became wor	told her they were short- ent indicated she received ne (pain medication) due to ed how her pain had been she en surprised that her pain only having been the highest) ait so long. She pushed her nd wanted the pills but when y told her they were busy and ne time she received the pills ecause she was mad and	F	725			
F 812 SS=F	D, Licensed Practic lights as probably r minutes, due to sta member stated Re on the toilet/command 15 minutes.	on 1/5/22 at 3:16 p.m. Staff cal Nurse (LPN) confirmed call not answered within 15 off shortages. The staff sident #5 had been left to sit ode the other day for 1 hour ,Store/Prepare/Serve-Sanitary 1)(2)	F {	312			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		165533	B. WING _		02	/01/2022	
NAME OF PROVIDER OR SUPPLIER  QHC HUMBOLDT NORTH, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1111 11TH AVE NORTH HUMBOLDT, IA 50548	•		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH CROSS-REFERENCED TO THE APPLICATION OF THE APPLICA	OULD BE	(X5) COMPLETION DATE	
F 812	Continued From pa	ge 20	F 8′	2			
	§483.60(i) Food sa The facility must -	fety requirements.					
	approved or considerate or local author (i) This may include from local producer and local laws or received ii) This provision of facilities from using gardens, subject to safe growing and for (iii) This provision of from consuming for serve food in according from serve food in according from the REQUIREMENT of the REQUIREMENT of the safe and staff interviews safe and sanitary for preparation areas. of 39 residents.	e food items obtained directly rs, subject to applicable State egulations. Does not prohibit or prevent a produce grown in facility compliance with applicable pod-handling practices. Does not preclude residents pods not procured by the facility.  The prepare is a footnoted by the facility.  The propare is a footnoted by the facility.  The propare is a footnoted by the facility.					
	revealed a build up	on 1/5/22 at 12:44 p.m. of dust, dirt, debris and a substance surrounded by a					
	brown/tan ring on the in the kitchen.  An email received of	on 1/18/22 at 5:33 p.m. that revealed the same build					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (2)		L' IDENTIFICATION NUMBER.		IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
		165533	B. WING _		02	/01/2022	
	PROVIDER OR SUPPLIER	c		STREET ADDRESS, CITY, STATE, ZIP ( 1111 11TH AVE NORTH HUMBOLDT, IA 50548			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 925 SS=E	CFR(s): 483.90(i)(4) §483.90(i)(4) Maint program so that the rodents. This REQUIREMED by: Based on observat facility staff failed to of vermin. The facility staff failed to of vermin.  During an interview F, Certified Nursing she observed bugs  During an interview B, CNA stated she bottom dresser dra out.  During an interview G, CNA confirmed the hallways.  During an interview During an interview of the hallways.	ain an effective pest control efacility is free of pests and NT is not met as evidenced tion and staff interview the maintain an environment free lity identified a census of 39 on 1/5/22 at 12:17 p.m. hount of dead bugs (flies, known varieties) and worms exit door at the end of hall of on 1/5/22 at 1:45 p.m. Staff a Assistant (CNA) confirmed in resident bathrooms.  If on 1/5/22 at 2:27 p.m. Staff recently opened a resident's wer and a huge spider climbed on 1/5/22 at 2:53 p.m. Staff she visualized dead bugs in the on 1/5/22 at 4:05 p.m. Staff call Nurse (LPN) stated he may	F 92	25			